SECTION 3

Right person, right skills, safe practice environment

1. Overview

The scope of clinical practice of each nurse practitioner is specific to the context of practice and is determined by the specialty in which the nurse practitioner is educated, competent and authorised to practise.

The NMBA does not define a nurse practitioner’s scope of practice. This is self-regulated and guided by the Australian Nursing and Midwifery Council’s (ANMC) National Framework for the Development of Decision-Making Tools for Nursing and Midwifery Practice (2007).

The NMBA’s function is to regulate the nursing and midwifery profession and set the standards for practice, including the nurse practitioner role. This function is distinctly different from an employer’s responsibility to manage an individual’s fitness for employment through clinical governance mechanisms, such as credentialing. In particular, the NMBA does not:

- ensure the individual has the correct skills and qualifications for the defined position
- define the clinical services, procedures or other interventions for which a nurse practitioner is competent to practise autonomously
- verify the quality of health services provided by a nurse practitioner
- consider the capability of the employer or health service facility to reasonably support the practice of the nurse practitioner.

In common with all other health professionals, the relevant laws, codes and standards that are unambiguous in their requirement that nurse practitioners have a professional duty only to practise where they are competent to do so, and not engage in any activities that may put patients, or other members of the public, at unwarranted risk of harm. Failure to comply may lead to disciplinary action, civil litigation and/or criminal prosecution being taken against the nurse practitioner.

Despite this requirement, the Queensland Health Systems Review (2005) and the Queensland Public Hospitals Commission of Inquiry (2005) highlighted that there is a small percentage of all health professionals who cannot be relied on to practise within their level of competence. Both reviews clearly demonstrated that a robust clinical governance framework is essential to ensure health services are provided only by competent practitioners in environments that support safe service provision.
2. Guideline

The fundamental aim for applying a consistent credentialing framework to health professionals is to:

- reduce harm to patients and improve the safety and quality of health care through regular review of clinical performance and professional development activities
- extend the traditional concepts of credentialing and defining scope of practice to incorporate the concept of a strong, mutual relationship, between employing or contracting organisations and each health practitioner, centred on the safety and quality of health care (ACQSHC, 2004).

3. Nurse practitioner candidates

The training and development of nurse practitioner candidates is essential for ensuring sustainability of the nurse practitioner role in Queensland, and ensures succession planning for these specialist roles and continuity of services.

3.1 Definition

A nurse practitioner candidate is a registered nurse undertaking an accredited university Masters program leading to endorsement as a nurse practitioner with the NMBA.

The nurse practitioner candidate may be employed in a designated position established by the employer.

The term 'nurse practitioner candidate' recognises the extended clinical practice role these registered nurses undertake as part of the clinical component/requirement of the Masters program. The focus of the nurse practitioner Masters program is to transition the registered nurse professionally to competently undertake the responsibilities of the nurse practitioner role, engaging in supervised extended clinical practice and formalised skill development in the nursing specialty in which they intend to practise.

3.2 Employment as a nurse practitioner candidate

While some individuals undertaking the Masters program leading to endorsement as a nurse practitioner are not employed as nurse practitioner candidates, there is currently capacity within some Queensland nursing career structures for employment as a nurse practitioner candidate.

Specific criteria apply to be appointed to such a position, and the organisation must have funding and infrastructure to support this developmental position.

3.3 Clinical internship or supported clinical practice

A nurse practitioner is required to exercise high-level clinical decision-making skills in the diagnosis and management of clients in a clinical nursing specialty.
The preparation of the nurse practitioner candidate requires the integration of academic theory with clinical practice, as well as the mastery and application of advanced clinical assessment, diagnostic skills, knowledge and competence in pharmacotherapy and other treatment modalities.

The clinical internship or supported clinical practice is based on an immersion approach to clinical learning. It involves any nurse practitioner learning experience, including simulated environments or clinical placements, that assist students to put theoretical knowledge into practice within the clinical setting. This should not be limited to the hospital setting. Consideration should also be given to general practice, remote and rural health clinics and community care environments.

This supported immersion approach to clinical learning for the nurse practitioner candidate has been demonstrated to be instrumental in testing both the parameters and expansion of the nurse practitioner role, and effective for achieving learning outcomes, while ensuring patient safety (Gardner, Gardner & Proctor, 2004).

Each university curricula has particular learning requirements. The nurse practitioner candidate must be provided with formal documentation from the university outlining the specific academic and clinical practice (internship) requirements for the particular nurse practitioner Masters program.

Employers are encouraged to employ nurse practitioner candidates in an advanced practice role in the clinical nursing specialty in which they intend to practise as a nurse practitioner. An example of this arrangement may be a minimum of 0.4 full-time-equivalent, or a block placement for a defined period of time.

Local arrangements may differ from these examples, and registered nurses considering entry to the Masters program leading to endorsement as a nurse practitioner should discuss the options and opportunities with their employer or local nursing management team, and refer to local policies relevant to these arrangements.

### 3.4 Clinical supervision and mentoring

Medical support, clinical teaching and mentorship are essential for effective skills development for the nurse practitioner candidate. Equally important is an adequate teaching and learning framework, with clarity in cross-disciplinary communication of the required learning experiences for nurse practitioner competency development and assessment outcomes.

The candidate should negotiate with the health service to establish an appropriate clinical support team for the duration of the Masters program. This team provides teaching through supervision, monitoring and review of the extended practice aspects of the nurse practitioner candidate’s role. The clinical support team also participates in the candidate’s formal university assessment process.

The clinical support team should be drawn from within the multidisciplinary service, be relevant to the nominated clinical speciality, and include at least a senior, experienced registered nurse and a clinician with appropriate expertise and experience, such as a medical specialist or nurse practitioner, as the primary clinical mentor.

It should also be acknowledged that clinical supervision and mentoring is in addition to the usual clinical work arrangements of the mentor, and as a result, may impact upon the time available for the mentor to undertake usual clinical activities and responsibilities.
Supervision and mentoring principles:
The following five principles will assist the clinical support team, the clinical mentor and the nurse practitioner candidate to collaborate in achieving a successful and productive clinical internship:

1: Clear communication

Clear communication between the university and the clinical support team, in particular, the clinical mentors, must be established for teaching and learning requirements for the Masters program. This will be in the form of a ‘learning contract’ or handbook that includes the following information:

- description of the clinical and leadership competencies to be achieved and relevant timeframe
- learning objectives for competencies and skill acquisition
- practice activities and performance expectations specific to the learning objectives
- assessment requirements and reporting structures
- information on contingencies for management of candidates who are not meeting the requirements of the program.

2: Hands-on clinical teaching and coaching

The nurse practitioner internship includes requirements for competency development in physical examination, clinical reasoning, procedures and other activities related to extended practice in a specialty field.

Adequate opportunity for observation and supervised practice of these skills and activities is essential to a comprehensive and successful clinical internship and the professional development of a competent clinician.

3: Surveillance of clinical performance

It is important that processes are in place for monitoring the performance of the candidate throughout their program of study. Scheduled reviews will ensure quality patient outcomes and the development of a competent work-ready clinician. This review process can be linked to formal performance appraisal and development processes, formal university requirements for assessment, or may be a part of regular clinical audit, peer review or review of data pertaining to the nurse practitioner candidate caseload.

Through the processes described above, the clinical mentor and other relevant team members will review the candidate’s assessment and management plan for patients’ episodes of care. This activity will provide a forum for:

- teaching and learning
- formative assessment
- identification of further learning requirements.

4: Skilled mentors

The clinical mentor is an essential component of the nurse practitioner internship. Mentor teaching is central to the process of the nurse practitioner developing the skills, knowledge and clinical reasoning necessary for transition to the nurse practitioner role.
The role of the clinical mentor is to establish a learning partnership with the nurse practitioner candidate to assist the candidate to apply clinical knowledge and to build clinical expertise in extended nursing practice for their specialist field. This will depend on the mentor having the specific skills, attitudes and commitment to the student, and a good understanding of the nurse practitioner role and service model.

5: Observance of legal structures

The purpose of supported learning is to enable the candidate to deepen and extend their knowledge and practice skills by ‘working into the role’ of a nurse practitioner.

The clinical mentor will meet some of the requirements for the extended practice aspects of the candidate’s practice, as delegated. This specifically relates to prescribing restrictions, requesting diagnostic tests and referring patients to other health professionals.

Strategies to achieve clinical learning outcomes in these activities can be negotiated between the candidate and the clinical mentor. These might include established practices such as:

• standing orders for medication
• protocols for registered nurses to initiate pathology and diagnostic imaging
• real-time case conferences led by the candidate
• shadowing the candidate to monitor clinical decision-making
• graduated responsibilities.

Decisions about these strategies will be made on the understanding that the candidate must practise within the legislated parameters of nursing practice (for the registered nurse) and that practice extending beyond this scope must be monitored and supported by a medical practitioner, and where possible, an endorsed nurse practitioner.

3.5 Nurse practitioner endorsement

When a nurse practitioner candidate completes the requirements of the Masters education program and can demonstrate the competency requirements for endorsement as a nurse practitioner by the NMBA, there is no automatic appointment to a nurse practitioner position. Appointment to a nurse practitioner position is a decision for an employer, subject to health service planning, funding allocation, creation of a position and a merit-based selection process.

It is not appropriate for a registered nurse with endorsement to use the authority and title of this endorsement, and practise as a nurse practitioner, if this is beyond the scope of the position in which the nurse is employed at that time.

Information on the endorsement process for nurse practitioners is available on the NMBA site at www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx
4. Credentialing and defining the scope of clinical practice

<table>
<thead>
<tr>
<th>Mandatory requirement</th>
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<tbody>
<tr>
<td>Nurse practitioners must be credentialed, and their scope of clinical practice defined by a process consistent with the:</td>
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<tr>
<td>• Australian Commission For Quality and Safety In Health Care (ACQSHC) (2004) National standard for credentialing and defining the scope of clinical practice (the National Standard)</td>
</tr>
<tr>
<td>• Health Quality and Complaint Commission’s (2010) Credentialing and scope of clinical practice standard (the HQCC Standard)</td>
</tr>
<tr>
<td>• Credentialing and Defining the Scope of Clinical practice for Nurse Practitioners in Queensland Health — Policy and Implementation Standard</td>
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4.1 Definition

The fact that a person holds qualifications as a nurse practitioner should not be regarded as entitling that person to unrestricted practice in any health service setting. In particular, due regard must be given to whether:

- the nurse practitioner’s qualifications or experience are confined to a particular area of practice
- practice restrictions may be required with consideration to the clinical service capability and resources available within a hospital or other health service setting (e.g. some procedures cannot be performed effectively without certain pathology or radiology services)
- there is sufficient volume of patients to maintain a nurse practitioner’s skills and competence (irrespective of workforce availability).

This process is known as ‘credentialing and defining the scope of clinical practice’.

‘Credentialing’ refers to the formal process used by an employer to verify the qualifications, experience, professional standing and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality health care services within specific organisational environments (ACSQHC, 2004).

‘Defining the scope of clinical practice’ (formally known as clinical privileges) follows on from credentialing and involves delineating the extent of an individual health practitioner’s clinical practice within a particular organisation, based on the individual’s credentials, competence, performance and professional suitability, and the needs and the capability of the facility to support the practitioner’s scope of clinical practice (ACSQHC, 2004).

This is in addition to professional self-regulation and individual accountability for clinical judgement that are an integral part of clinical governance.

4.2 Credentialing principles

The national standard is based on the following principles:

- credentialing and defining the scope of clinical practice are organisational governance responsibilities that are always conducted to maintain and improve the safety and quality of health care services
processes of credentialing and defining the scope of clinical practice are complemented by health practitioner registration requirements and individual professional responsibilities that protect the community.

- effective processes of credentialing and defining the scope of clinical practice benefit patients, communities, health care organisations and nurse practitioners.

- credentialing and defining the scope of clinical practice are essential components of a broader system of organisational management of relationships with health practitioners.

- reviewing the scope of clinical practice should be a non-punitive process.

- processes of credentialing and defining the scope of clinical practice depend for their effectiveness on strong partnerships between health care organisations and professional colleges, associations and societies.

- processes of credentialing and defining the scope of clinical practice must be fair, transparent and legally robust.

### 4.3 Adopting Queensland Health’s policy

Queensland Health’s policy for credentialing and defining the scope of clinical practice for nurse practitioners may be adopted by non-government organisations.

The Queensland Health Implementation Standard may be adapted and customised where necessary, provided consistency with the national standard is maintained.

A supporting policy and implementation standard for *Credentialing and Defining Scope of Clinical Practice for Nurse Practitioners in Queensland Health* will be available in 2011.

### 5. Outcomes

The following five outcomes should be achieved:

1. Every nurse practitioner is credentialed and their scope of clinical practice defined and documented before commencing practice with one of the following (the approving entity):

   (a) where the nurse practitioner is engaged in a public sector health service operated by Queensland Health — the chief executive of the health service district, local hospital network or statewide health service under the *Health Services Act 1991*, in which the nurse practitioner is engaged.

   (b) where the nurse practitioner is engaged by a private hospital or day surgery licensed under the *Private Health Facilities Act 1999* — the chief executive of the private health facility in which the nurse practitioner is engaged.

   (c) where a nurse practitioner is otherwise employed under a contract of employment or a contract for services — a health practitioner who is the employer, or a delegate of the employer, and holds current registration under the *Health Practitioner Regulation National Law Act 2009* with no conditions or undertakings.

   (d) in all other cases, an interdisciplinary team including at least a registered nurse, a medical practitioner and a pharmacist, who each
hold current registration under the *Health Practitioner Regulation National Law Act 2009* with no conditions or undertakings.

2. The approving entity has used a process for credentialing and defining scope of clinical practice of nurse practitioners that is consistent with the *Credentialing and Defining the Scope of Clinical Practice for Nurse Practitioners in Queensland Health*, the national standard and the Health Quality Complaints Commission (HQCC) standard.

3. The defined scope of practice of each nurse practitioner is appropriate and consistent with:
   - the clinical services capability of the health service setting
   - the practice scope of the position in which the nurse practitioner is engaged
   - the individual’s qualifications and competence
   - any conditions imposed by, or undertakings made with, the NMBA or any other regulator.

4. The approving entity reviews the credentials and scope of clinical practice of each nurse practitioner within a period not exceeding three years, or when circumstances change affecting the individual nurse practitioner.

5. The approving entity has a process to support the restriction or suspension of any nurse practitioner’s scope of clinical practice within the health service setting.
SECTION 4

Extended clinical practice

1. Overview

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations (Australian Nursing and Midwifery Council, 2006).

2. Guideline

1. Nurse practitioners must only use those extended practice privileges that are appropriate and necessary to practice nursing within:
   - the practice scope of the position in which the nurse practitioner is engaged
   - their education, competence and defined scope of clinical practice.

2. Nurse practitioners must establish and maintain collaborative arrangements with all health professionals involved in the care of the patient, based on inter-professional respect, effective communication and collective action to optimise health outcomes.

3. Continuing professional development

Under the national law, which governs the operations of the national boards and Australian Health Practitioner Regulation Authority (AHPRA), all registered health practitioners must undertake continuing professional development. Continuing professional development is the means by which members of a profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives (Nursing and Midwifery Board of Australia (NMBA, 2010)).

All nurse practitioners must meet the NMBA continuing professional development standard, and are required to demonstrate competence in relation in their context of practice and endorsement. Mandatory requirements set down by the NMBA to maintain registration as a registered nurse and endorsement as a nurse practitioner includes completion of at least:

(a) 20 hours of continuing nursing professional development per year

(b) 10 hours per year of education related to their endorsement as a nurse practitioner.
Nurse practitioners must also keep written documentation of continuing professional development that demonstrates evidence of completion of the requirements set down by the board on an annual basis.

4. Prescription of medicines

4.1 Statutory authority

Provisions within the Queensland *Health (Drugs and Poisons) Regulation 1996* authorise nurse practitioners to the extent necessary to practise nursing to obtain, possess, administer, supply and prescribe medicines.

4.2 Drug Therapy Protocol for Nurse Practitioners

The *Drug Therapy Protocol for Nurse Practitioners* is certified by the Chief Executive, Director-General, Queensland Health under the *Health (Drugs and Poisons) Regulation 1996*.

It is a condition of the *Drug Therapy Protocol for Nurse Practitioners* that a nurse practitioner may only prescribe, give a written or oral instruction, supply and administer the controlled and restricted drugs or poisons that are necessary to practise nursing within the defined nurse practitioner model of care in which the nurse practitioner is engaged to practise.


<table>
<thead>
<tr>
<th>Mandatory requirement</th>
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<tr>
<td>Practice scope of the nurse practitioner position must be defined for a nurse practitioner to act under the <em>Drug Therapy Protocol for Nurse Practitioners</em>. The Drug Therapy Protocol states the circumstances in which, and the conditions under which, a nurse practitioner may prescribe, give a written or oral instruction, supply and administer a stated controlled or restricted drug or poison under the <em>Health (Drugs and Poisons) Regulation 1996</em>.</td>
</tr>
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</table>

4.3 Components of prescribing

Nurse practitioners use evidence-based guidelines to facilitate decision-making for prescribing medications. They are not directed by rigid protocol-based prescribing, but have comprehensive knowledge of pharmacology and pharmacokinetics related to a specific field of clinical practice.

There are essentially four components to prescribing (Coombes, 2007). Refer to figure 5 on page 34.
4.4 Prescribing competency framework

The following prescribing competency framework (incorporating ‘the consultation’, ‘prescribing safely and effectively’, and ‘prescribing in context’), describes the knowledge and skills required for prescribing.

**The consultation**

**Clinical and pharmaceutical knowledge**

The nurse practitioner has up-to-date clinical and pharmaceutical knowledge relevant to own area of practice, including:

- understanding the medical conditions being treated, their natural progress and how to assess their severity
- understanding different non-pharmacological and pharmacological approaches to modifying disease or conditions; promoting health, desirable and undesirable outcomes; and how to identify and assess them
- understanding the mode of action and pharmacokinetics of medicines, how these mechanisms may be altered (e.g. by age, renal impairment) and how this affects dosage
• understanding the potential for unwanted effects (e.g. allergy, adverse drug reactions, drug interactions, special precautions and contraindications), and how to avoid or minimise, recognise and manage them
• maintaining an up-to-date knowledge of products in the Australian Medicines Handbook (AHM), List of Approved Medicines (LAM), and other formularies (e.g. doses, formulations, pack sizes, storage conditions, costs)
• understanding how medicines are licensed, monitored (e.g. adverse drug reaction reporting) and supplied
• applying the principles of evidence-based medicine, clinical and cost-effectiveness
• understanding the public health issues related to medicines’ use
• appreciating the misuse potential of medicines.

Establishing options (involving carers, parents and/or advocates where appropriate)

The nurse practitioner reviews diagnosis, generates treatment options for the patient and follows up treatment within the scope of the clinical management plan, including:
• taking and/or reviewing the medical and medication history, and undertaking a physical examination, where appropriate
• views and assesses the patient’s needs holistically (i.e. psychosocial, physical)
• accessing and interpreting all relevant patient records to ensure knowledge of the patient’s management
• reviewing the nature, severity and significance of the diagnosis or clinical problem
• requesting and interpreting relevant diagnostic tests
• considering no treatment, non-drug and drug treatment options (including referral and preventive measures)
• assessing the effect of multiple pathologies, existing medication and contraindications to treatment options
• assessing the risks and benefits to the patient of taking or not taking a medicine (or using or not using a treatment)
• selecting the most appropriate medicine, dose and formulation for the individual patient, and prescribing appropriate quantities
• monitoring effectiveness of treatment and potential side-effects
• establishing, monitoring and making changes within the scope of the clinical management plan, in light of the therapeutic objective and treatment outcome
• ensuring that patients can access ongoing supplies of their medication.

Communicating with patients (involving carers, parents and/or advocates where appropriate)

The nurse practitioner establishes a relationship based on trust and mutual respect, sees patients as partners in the consultation, and applies the principles of concordance, including:
• ensuring that the patient understands and consents to be managed by a prescribing partnership, in accordance with local arrangements
• listening to and understanding patients’ beliefs and expectations
• understanding the cultural, language and religious implications of prescribing
• adapting consultation style to meet the needs of different patients (e.g. for age, level of understanding, physical impairments)
• dealing sensitively with patients’ emotions and concerns
• creating a relationship that does not encourage the expectation that a prescription will be written
• explaining the nature of the patient’s condition and the rationale behind, and potential risks and benefits of, management options
• enabling patients to make informed choices about their management
• negotiating an outcome to the consultation that both patient and prescriber are satisfied with
• encouraging patients to take responsibility for their own health and self-manage their conditions
• giving clear instructions to the patient about their medication (e.g. how to take or administer it, where to get it from, possible side-effects)
• checking the patients understanding of, and commitment to, their treatment.

Prescribing safely and effectively

Prescribing safely

The nurse practitioner is aware of their own limitations, does not compromise patient safety and justifies prescribing decisions, including:

• knowing the limits of their own knowledge and skill, and working within them
• knowing how and when to refer back to, or seek guidance from, the independent prescriber, another member of the team or a specialist
• only prescribing a medicine with adequate, up-to-date knowledge of actions, indications, contraindications, interactions, cautions, dose and side-effects
• knowing about common types of medication errors and how to prevent them
• making prescribing decisions often enough to maintain confidence and competence
• keeping up to date with advances in practice and emerging safety concerns relating to prescribing
• understanding the need for, and making, accurate and timely records and clinical notes
• writing legible, clear and complete prescriptions that meet legal requirements
• checking doses and calculations to ensure accuracy and safety.

Prescribing professionally

The nurse practitioner works within professional, regulatory and organisational standards, including:

• accepting personal responsibility for their own prescribing in the context of a shared clinical management plan, and understanding the legal and ethical implications of doing so
• using professional judgement to make prescribing decisions based on the needs of patients and not the prescribers’ personal considerations
• understanding how current legislation affects prescribing practice
• prescribing within current professional and organisational codes of practice or standards
• keeping prescription pads safely, and knowing what to do if they are stolen or lost.

**Improving prescribing practice**

The nurse practitioner actively participates in the review and development of prescribing practice to improve patient care, including:

• reflecting on their own performance, with the ability to learn and change prescribing practice
• sharing and debating their own, and others’ prescribing practice (e.g. audit, peer group review, etc.)
• constructively challenging colleagues’ inappropriate practice
• understanding and using tools to improve prescribing (e.g. review of prescribing analysis and cost tabulation [PACT], prescribing data and feedback from patients)
• reporting prescribing errors and near-misses, and reviewing practice to prevent recurrence
• developing their own networks for support, reflection and learning
• establishing multi-professional links with practitioners working in the same specialist area
• taking responsibility for their own continuing professional development.

**Prescribing in context**

**Information in context**

The nurse practitioner knows how to access relevant information, and can critically appraise and apply information in practice, including:

• understanding the advantages and limitations of different information sources
• using relevant, up-to-date information, both written (paper or electronic) and verbal
• critically appraising the validity of information (e.g. promotional literature, research reports, etc.) when necessary
• applying information to the clinical context (linking theory to practice)
• using relevant patient record systems, prescribing and information systems and decision-support tools
• regularly reviewing the evidence behind therapeutic strategies.

**The health care system in context**

**Note:** Most of these points apply more generally

The nurse practitioner understands and works with local and national policies that impact on prescribing practice, and sees how their own practice impacts on a wider health care system, including:

• understanding the framework of supplementary prescribing and how it is applied in practice
• understanding and working with local health care organisations and relevant agencies contributing to health improvement (e.g. social services)
• working within local frameworks for medicines’ use as appropriate (e.g. formularies, protocols and guidelines)
• working within the organisational code of conduct when dealing with the pharmaceutical industry
• understanding drug budgetary constraints at local and national levels, and discussing them with colleagues and patients
• understanding national frameworks for medicines’ use (e.g. Quality Use of Medicines, National Prescribing Service, medicines management, clinical governance, information technology strategy, etc.).

The team and individual context

The nurse practitioner works in partnership with colleagues for the benefit of patients and is self-aware and confident in their own ability as a prescriber, including:
• relating to the independent prescriber as an equal partner
• negotiating with the independent prescriber to develop and agree on clinical management plans
• thinking and acting as part of a multidisciplinary team to ensure that continuity of care is not compromised
• establishing relationships with colleagues based on understanding, trust and respect for each other’s roles
• recognising and dealing with pressures that may result in inappropriate prescribing
• being adaptable, flexible, proactive and responsive to change
• seeking and/or providing support and advice to other prescribers, team members and support staff where appropriate
• negotiating the appropriate level of support for their role as a prescriber.

4.5 List of personal or preferred drugs (P-drugs)

Nurse practitioners are required to develop a comprehensive list of medications that are used regularly in their practice. This will reflect the practice scope of the position in which the nurse practitioner is employed. The AMH recommends that a list of personal or P-drugs is essential for safe prescribing.

Prescribers need to be confident in their ability to evaluate information about drugs and to determine their therapeutic value.

Confidence is enhanced by having a personal list of preferred drugs and becoming thoroughly familiar with their use.

4.6 Supplementary prescribing

Supplementary prescribing is ‘a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific clinical management plan with the patient’s agreement’ (Department of Health UK 2005).
Supplementary prescribing is intended to provide patients with faster and more efficient access to medicines, and to make the best use of the clinical skills of nurse practitioners.

Supplementary prescribing is primarily intended for use in managing specific long-term medical conditions or health needs affecting the patient.

For example, a consultant medical practitioner in an urban area may be treating a patient who resides in remote Queensland. The consultant medical practitioner may consider a supplementary prescribing arrangement with a nurse practitioner in rural and isolated practice who is more accessible to the patient.

The supplementary prescribing plan must be drawn up, with the patient’s agreement, following diagnosis of the patient by the consultant medical practitioner, and consultation and agreement between the consultant medical practitioner and nurse practitioner. The nurse practitioner must be satisfied the supplementary prescribing plan is within the nurse practitioner’s education, skills and competence.

The supplementary prescribing plan must be in writing and include arrangements for regular communication with the consultant medical practitioner, and regular clinical reviews of the patient’s progress by the consultant medical practitioner. A copy of the plan should be made available to the dispensing hospital or community pharmacist if requested.

The nurse practitioner has discretion in the choice of dosage, frequency, product and other variables in relation to medicines only within the limits specified by the supplementary prescribing plan.

The plan may include reference to recognised clinical guidelines as an alternative to listing medicines individually. Any guidelines referred to should be readily accessible to the nurse practitioner when managing the patient’s care.

Where another health professional is the lead clinician responsible for the diagnosis and management plan, the arrangements for supplementary prescribing by the nurse practitioner must be documented in the medical record of the patient, and where practicable, the consultant medical practitioner and nurse practitioner should share the same patient record.

4.7 Quality use of medicines (QUM)

When using medicines, nurse practitioners must comply with the National Policy on the Quality Use of Medicines and ensure their prescribing practice is evidence-based and in accordance with the recognised clinical standards, practices and procedures for health care in Australia.

This means that a nurse practitioner must:

(a) not prescribe beyond the limits of their competence and experience

(b) only prescribe for a patient whom the nurse practitioner has assessed for care and there is evidence of a genuine clinical need for treatment

(c) select management options wisely by:
   (i) considering the place of medicines in treating illness and maintaining health
   (ii) recognising that there may be better ways than medicine to manage many disorders
   (iii) identifying relevant evidence-based guidelines to support decision-making
(d) choose suitable medicines if a medicine is necessary so that the best available option is selected by considering:
- the individual
- the clinical condition
- risks and benefits
- dosage and length of treatment
- any co-existing conditions
- other therapies
- monitoring considerations
- costs for the individual, the community and the health system as a whole.

(e) understand the pharmacokinetics and pharmacodynamics when prescribing for high-risk patient groups, including:
- neonates (0–28 days)
- young infants (1–3 months)
- infants (3 months–2 years)
- children (2–12 years)
- pregnant women
- breastfeeding women
- patients with renal impairment
- patients with hepatic impairment
- the elderly (>65 years, or Indigenous >50 years)
- treatment of persons for drug dependency (AMH, 2010).

(f) use medicines safely and effectively to get the best possible results by:
(i) monitoring outcomes
(ii) minimising misuse, over-use and under-use
(iii) improving people’s ability to solve problems about medication, such as negative effects or managing multiple medications.

5. Use of blood and blood components

5.1 Regulation

Blood, blood components and plasma derivatives are regulated under the *Therapeutic Goods Act 1989* (Commonwealth).

The Health (Drugs and Poisons) Regulation 1996 applies to plasma derivatives as prescription medicines, but does not apply to the use of whole blood and blood components.

The Queensland Blood Management Program (QBMP) was established in 2005 to ensure the Queensland Government meets its obligations under the National Blood Agreement.

The QBMP has a statewide Haemo-vigilance System (Queensland incidents in Transfusion — QiiT) that aligns with the National Haemo-vigilance System managed by the National Blood Authority.

The Australian Red Cross Blood Service provides comprehensive information for clinicians on individual blood components, the risks of transfusion, and consent.


5.2 Prescribing blood and blood components (blood transfusion)

The prescribing of blood and blood components by nurse practitioners is not appropriate unless blood transfusion is within the nurse practitioner’s education, competence, and defined scope of clinical practice.

The authority for a nurse practitioner to prescribe blood and blood components must be expressly stated in the approved practice scope of the nurse practitioner position, and the defined scope of clinical practice of the individual nurse practitioner.

Guidelines for the administration of blood components are available from the Australian & New Zealand Society of Blood Transfusion at www.anzsbt.org.au

6. Diagnostic services — Pathology

6.1 Pathology services

Nurse practitioners are authorised to use necessary pathology tests and investigations to practise nursing within the defined practice scope of the position in which the nurse practitioner is engaged.

The nurse practitioner’s responsibility commences with the decision to request a pathology test/investigation, and is maintained until the nurse practitioner has taken the appropriate clinical action in response to the report generated by the request. The nurse practitioner’s responsibility does not cease with the transfer of the request to the pathology provider.

6.2 Quality use of pathology

Nurse practitioners have a responsibility to have in place management systems to ensure requests are correctly initiated and acted upon and that pathology reports are communicated in an appropriate, clinically meaningful and timely fashion.

In accordance with this responsibility, the nurse practitioner (or their employer) must have systems in place to ensure the following.

(a) The informed cooperation and consent of the patient is obtained by informing the patient about the required tests and what the tests broadly involve, their foreseeable risks and benefits, and the implications of declining treatment. The information should be adapted to the patient’s needs.

(b) Where requesting tests or investigations for notifiable diseases, nurse practitioners should ensure the patient is aware of the nurse practitioner’s reporting obligations.

(c) Requests are correctly initiated by accurately completing a signed hard copy or electronic request form, including the relevant patient, clinical and test information.
(d) requested tests and investigations are identified using generally accepted names or acronyms.

(e) Overdue reports are identified and followed up with minimum delay.

(f) Pathology reports are acted on appropriately and in a timely manner.

(g) In the absence of the nurse practitioner, a suitable delegate has been nominated to receive and act on the result.

(h) Support staff are provided with clear and sufficient documented policies and procedures for the managing of pathology requests and reports. This should include policies covering confidentiality and privacy.

Further guidance is available from the Chain of Information Custody for the Pathology Request-Test-Report Cycle in Australia (Guidelines for Pathology Requesters and Pathology Providers) produced by the Australian Government, Department of Health and Ageing.

6.3. AUSLAB Pathology Management System

Nurse practitioners (and nurse practitioner candidates) employed by Queensland Health can apply for access as requesting officers in the AUSLAB Pathology Management System.

The application needs to be approved by the relevant executive director of Nursing and forwarded to Laboratory Information Systems and Solutions, Clinical and Statewide Services.

The application form and more information are available from the site of Laboratory Information Systems and Solutions at qheps.health.qld.gov.au/liss/home.htm

6.4 Private pathology

Through the Medicare Benefits Schedule (MBS), the Australian Government funds private patient pathology service on fee-for-service arrangements through Medicare rebates.

Eligible nurse practitioners are able to request specific services listed in the pathology services table.

7. Diagnostic services — Diagnostic imaging

7.1 Diagnostic imaging

A request for a diagnostic imaging examination is regarded as a referral to a specialist for a clinical opinion which will assist in the diagnosis and future management of a particular clinical problem.

7.2 Requests

Nurse practitioners are authorised to request appropriate and necessary diagnostic imaging provided its use is within the scope of clinical practice of the nurse practitioner, and the use of the diagnostic imaging is not otherwise controlled or restricted by regulation.

The primary responsibilities of a nurse practitioner requesting diagnostic imaging are to:

- have a full knowledge of the potential benefit and detriment of the procedure
- be aware that many imaging tests have risks, and prevent unnecessary exposure to imaging procedures
- clarify the requirement for the diagnostic procedure by undertaking an accurate patient history, clinical assessment and examination
- provide the diagnostic imaging specialist with sufficient clinical data relevant to the request (such as relevant history, mechanism of injury, clinical signs and allergies/contraindications) and the main objective of the examination (clinical questions to be answered by performing the procedure)
- ensure requested diagnostic images are performed
- view, act upon and record the results of the diagnostic imaging studies
- consult or refer to other health professionals when the patient’s condition requires expertise beyond their own scope of competence.

7.3 Diagnostic Radiography Protocol

Under section 39A and Schedule 3A, Part 1, of the Radiation Safety Regulation 1999, a nurse practitioner, acting under a Diagnostic Radiography Protocol, is authorised to request plain film diagnostic imaging.

The Diagnostic Radiography Protocol is a document certified by the Director-General, Queensland Health and published by Queensland Health, which states the circumstances in which, and conditions under which, nurse practitioners (and other registered nurses authorised to act under the protocol) may request plain film diagnostic radiography.

A nurse practitioner may request plain film diagnostic radiography where the diagnostic procedure is within the scope of the position in which the nurse practitioner is engaged.

Ultrasound is not regulated in the same way, and may be used as a diagnostic investigation by nurse practitioners under local service arrangements.
The current Diagnostic Radiography Protocol dated 30 November 2006, is under review, and is available on the Queensland Health site at www.health.qld.gov.au

7.4 Diagnostic interpretation

An imaging report provides a specialist interpretation of diagnostic images and relates the findings, both anticipated and unexpected, to the patient’s current clinical symptoms and signs to diagnose or contribute to the understanding of their clinical condition. It often incorporates advice to the referring clinician on appropriate further investigation or management.

Caution must be exercised when interpreting, and acting upon, diagnostic imaging that is unreported. Nurse practitioners have a general responsibility to only interpret unreported diagnostic images within their knowledge and expertise.

Nurse practitioners should take reasonable precautions to ensure their interpretation is accurate and appropriate in the circumstances of the case.

The nurse practitioner must have collaborative arrangements in place with a medical practitioner to review unreported images, and to follow up imaging reports when available.

Where possible, communication on the findings of the report should be made with other health professionals involved in the patient’s care.

8. Medicare and the Pharmaceutical Benefits Scheme

8.1 National health care system

The national health care funding system provides eligible Australian residents, regardless of their personal circumstances, access to health care at an affordable, or no cost, while enabling individual choice through substantial private sector involvement in health care delivery and financing.

The Australian Government’s health funding includes three major national subsidy schemes:

- Medicare — Australia’s universal health care program
- Pharmaceutical Benefits Scheme (PBS)
- Federal Government 30 per cent rebate on private health insurance.

8.2 Medicare Benefits Schedule (MBS)

The Australian Government Department of Health and Ageing is responsible for the Medicare Benefit Schedule (MBS) which lists the services and unique item numbers for which a Medicare benefit is payable.

More information can be found on the Department of Health and Ageing’s site at www.health.gov.au and Medicare Australia’s site at www.medicareaustralia.gov.au

‘Eligible nurse practitioners’ are able to provide certain services listed within the MBS provided those services are within the nurse practitioner’s authorised scope of practice and level of experience and competence.
Eligibility to access Medicare benefits is determined by the *Health Insurance Act 1973* (Cth) and related regulations.

The *Health Insurance Act 1973* can be found at [www.comlaw.gov.au](http://www.comlaw.gov.au)

### 8.3 Pharmaceutical Benefits Scheme (PBS)

‘Eligible nurse practitioners’ are enabled to prescribe certain medicines under Commonwealth subsidy (commonly known as the Pharmaceutical Benefits Scheme (PBS)), by which the Commonwealth provides access to a wide range of medicines for all Australians.

The PBS arrangements are governed by the *National Health Act 1953* (Cth) and the *National Health (Pharmaceutical Benefits) Regulations 1960* (Cth) which can be found at [www.comlaw.gov.au](http://www.comlaw.gov.au)

More information about the PBS can be found at [www.pbs.gov.au](http://www.pbs.gov.au)

In Queensland, some Queensland Health facilities will participate in arrangements with the Commonwealth to enable access to PBS in some public hospitals. It is important that patients are not financially disadvantaged as a result of nurse practitioner prescribing.

#### Mandatory requirements

- To be authorised to prescribe under the PBS, a nurse practitioner must:
  - be authorised to prescribe medicines within their scope of practice under State or Territory law
  - be issued by Medicare Australia with a PBS prescriber number (which must be stated in each PBS prescription written by the nurse practitioner)
  - provide treatment in a collaborative arrangement with one or more medical practitioners.

### 8.4 Repatriation Pharmaceutical Benefits Scheme (RPBS)

Prescribing by eligible nurse practitioners under the PBS will also apply for supply of pharmaceutical benefits under the Repatriation Pharmaceutical Benefits Scheme (RPBS).

More information can be found on the Commonwealth Department of Veterans Affairs site at [www.dva.gov.au](http://www.dva.gov.au)

### 8.5 Eligible nurse practitioner

To be eligible to access the MBS and PBS, each nurse practitioner must register with Medicare Australia for a unique Medicare provider number and PBS prescriber number for each practice location.

#### Meaning of eligible nurse practitioner

Under section 84AAI, of the *National Health Act, 1953*

A person is an eligible nurse practitioner if the person:

(a) is a nurse practitioner

(b) meets the requirements (if any) set out in a determination made under Subsection (2) of the Act.
The Federal Minister for Health and Ageing may, by legislative instrument, determine one or more requirements that a specified person must meet in order to be an eligible nurse practitioner for the purposes of this Act.

Medicare Australia provider numbers are also allocated to enable nurse practitioners to request certain diagnostic imaging and eligible pathology services as set out in the MBS.

An eligible nurse practitioner applying for a provider number must be in private practice, and services claimed under this initiative must be performed while working in a private capacity. In some circumstances, exemptions may apply.

Medicare Australia has created a series of interactive eLearning modules to help nurse practitioners understand their obligations under the MBS and PBS. These are available at www.medicareaustralia.gov.au/provider/business/education/e-learning.jsp

Nurse practitioners establishing a private practice as an ‘eligible nurse practitioner’ are required to obtain adequate professional indemnity insurance and are advised to seek appropriate legal and financial advice.

Mandatory requirements

The National Health (Collaborative arrangements for nurse practitioners) Determination 2010 specifies the kind of collaborative arrangements required for a nurse practitioner to access the MBS and PBS:

(a) The nurse practitioner is employed or engaged by one or more medical practitioners, or by an entity that employs or engages one or more medical practitioners.
(b) A patient is referred, in writing, to the nurse practitioner for treatment by a medical practitioner.
(c) A written and signed agreement is made between a nurse practitioner and one or more medical practitioners.
(d) An arrangement, recorded in the nurse practitioner’s written records, is made with a named medical practitioner who has acknowledged they will be collaborating with the nurse practitioner in a patient’s care.

In each case, the collaborative arrangement must provide for:

(a) consultation between the nurse practitioner and a medical practitioner
(b) referral of a patient to a medical practitioner
(c) transfer of a patient’s care to a medical practitioner.

A collaborative arrangement (other than the arrangement described in (d) above) may apply to more than one patient.
9. Delegation, referral and clinical handover

Central to the nurse practitioner’s care of the patient is clear and effective communication with other members of the health care team. Delegation, referral and clinical handover are three key areas where concise communication will provide for effective care of the patient.

In some circumstances, the nurse practitioner will be required (adapted from Medical Board of Australia 2010) to:

- delegate specific tasks or activities to a nurse or another health care professional to provide care on the nurse practitioner’s behalf while the nurse practitioner retains overall responsibility for the patient’s care. Although the nurse practitioner will not be accountable for the decisions and actions of those to whom they delegate, the nurse practitioner remains responsible for the overall management of the patient, and for their decision to delegate

- refer a patient to obtain opinion or treatment from another health care professional. This usually involves the transfer (in part) of responsibility for the patient’s care, usually for a defined time and for a particular purpose, such as care that is outside the nurse practitioner’s area of expertise

- hand over the patient’s care by transferring all responsibility to another health care professional.

Nurse practitioners have a responsibility to identify clinicians and services (internal and external to the health service) likely to constitute referral networks supporting their clinical practice. They are also required to negotiate with these clinicians and services about accepting and acting upon nurse practitioner-generated delegation, referral and handover.

Nurse practitioners must ensure that:

- the person to whom they delegate, refer or hand over has the qualifications, experience, knowledge and skills to provide the care required

- sufficient information is communicated about the patient and the treatment they require to enable the continuing care of the patient

- it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient.

Using a standardised approach to the handover will ensure effective transfer of information and responsibility for patient care between health professionals. There are a number of standardised tools that can be adopted to support the handover process. One example is the SBAR framework – situation, background, assessment and recommendation. Refer to figure 6 on page 48.
Figure 6: SBAR tool

| S | Situation — state the patient’s diagnosis/reason for admission and the current problem |
|   | ‘The situation is that I have a patient (age/gender), who is (diagnosis/deteriorating/stable). |
|   | My concerns are (clear and succinct concerns). |
|   | The current presenting symptoms are (clear, current and relevant symptoms and observations).’ |

| B | Background — what is the clinical background or context? |
|   | By way of background (give pertinent information that may include: date of admission/presenting symptoms/medication/previous recent vital signs/test results/status changes) |

| A | Assessment — what do you think the problem(s) is? |
|   | (Don’t forget to have the current vital signs and a key problem list ready) |
|   | ‘My assessment on the basis of the above is that the patient is….. they are at risk of….. and in need of....’ |

| R | Recommendation — what are you asking the person to do? |
|   | ‘My recommendation is that this patient needs (what test/action) by (who) within (timeframe)’ |
|   | Repeat to confirm what you have heard. (e.g. ‘I understand that I am to…. and you will...’) |


Additional resources are also available at www.health.qld.gov.au/patientsafety/webpages/clinhand.asp

10. Issuing certificates

Nurse practitioners are frequently required to issue certificates certifying sickness or a medical condition.

Certificates are usually issued for the information of patients’ employers, but may also be required by insurers, and in court proceedings. The patient must be informed that ultimately it is up to the employer, insurer, magistrate or other party as to whether a certificate issued by a nurse practitioner will be accepted.

Nurse practitioners must ensure they are not restricted by law from issuing the certificate.
10.1 General principles

The following key points provide guidance for nurse practitioners when issuing a certificate:

- A certificate issued by a nurse practitioner must:
  - be legible
  - clearly identify the certificate is issued by an endorsed nurse practitioner as the treating health professional
  - include the signature of the nurse practitioner, the date of issue, the nurse practitioner’s registration number and the nurse practitioner’s practice address and contact details
  - not contain abbreviations or medical jargon
  - be based on facts known to the nurse practitioner. The certificate may include information provided by the patient but any clinical statements must be based upon the nurse practitioner’s own observations, or must indicate the factual basis of those statements.

- A certificate issued by a nurse practitioner must indicate:
  - the date on which the examination took place
  - whether the patient is totally incapacitated
  - the date on which the patient is likely to be able to return to work
  - be addressed to the party for whom the certificate is forwarded as evidence of illness (e.g. employer, insurer, magistrate).

- Under no circumstances should the examination date:
  - be backdated or antedated or post-dated to correspond with an existing or proposed absence from work
  - be other than the date on which the patient attended the nurse practitioner and at which consultation a genuine medical condition was observed or was considered, in the nurse practitioner’s judgement, to have been suffered in the recent past, or
  - be for days off work for holiday or special needs.

- A diagnosis should not be included in a certificate without a patient’s consent.

- A medical certificate may be issued by a nurse practitioner subsequent to a patient taking sick leave. In these circumstance, the certificate must:
  - state the date of the examination
  - clearly indicate whether it is based upon observations of signs and symptoms during the examination, or upon information provided by the patient which the nurse practitioner deems to be true, and cover the period during which the nurse practitioner believes the illness would have incapacitated the patient.

10.2 Workers’ Compensation Certificates

Under Section 132(3)(a) of the Workers’ Compensation and Rehabilitation Act 2003 (Qld), a nurse practitioner, acting under the Workers’ Compensation Certificate Protocol, is authorised to issue a Workers’ Compensation certificate for a minor injury; that is an injury which does not require admission to hospital to treat the injury.

The Workers’ Compensation Certificate Protocol is a document, co-certified by the Director-General, Queensland Health and the Chief Executive Officer, Q-Comp (Queensland’s Workers’ Compensation Regulatory Authority), and
published by Q-Comp, which states the circumstances and conditions under which a nurse practitioner may issue a Workers’ Compensation certificate.


It is a condition of the *Workers’ Compensation Certificate Protocol* that a nurse practitioner may only issue a workers’ compensation certificate for a minor injury:

(a) where assessment of the injury is within the clinical scope of the position in which the nurse practitioner is engaged

(b) for a total period of incapacity not exceeding 10 calendar days.

### 10.3 Centrelink

Under the *Social Security Act 1991* (Commonwealth), a Centrelink Medical Certificate can only be issued by a medical practitioner (sickness allowance, disability support pension, mobility allowance, Newstart, Youth Allowance, Parenting Payment with participation requirements or Special Benefit).

However, there are other provisions under the *Social Security Act 1991* that authorise a medical report to be provided by a treating health professional currently involved in the treatment of the Centrelink customer. These provisions also include reports from registered nurses and endorsed nurse practitioners (carer allowance and carer payment for adults and children).

Centrelink should be contacted to clarify requirements before issuing a certificate for Centrelink’s purposes.

### 10.4 *Fair Work Act 2009* (Commonwealth)

Under Section 12 of the *Fair Work Act 2009* (Commonwealth), a medical certificate for the purposes of that Act can be issued only by a medical practitioner.

This applies, for example where an employer may ask an employee for a medical certificate under sections 73, 74, 81 and 82 of the *Fair Work Act 2009* (‘Parental leave and related entitlements’).

### 11. Reportable deaths

#### 11.1 Cause of death certificate

Under Section 30 of the *Births, Deaths and Marriages Registration Act 2003* (Queensland), a ‘cause of death’ certificate may only be completed by a medical practitioner.

This does not limit a nurse practitioner’s obligation under the *Coroners Act 2003* (Queensland), which imposes a duty that anyone who becomes aware of a reportable death must report it to a coroner or the police if they do not reasonably believe that this has already occurred. Failure to report is a criminal offence.
Reportable deaths are defined in Section 8(3) of the *Coroners Act 2003* (Queensland) as deaths where:

- the identity of the person is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- a cause of death certificate has not been issued and is unlikely to be issued
- the death was a health care-related death
- the death occurred in care
- the death occurred in custody
- the death occurred as a result of police operations.

### 11.2 Health care related deaths

All health care-related deaths are reportable under the *Coroners Act 2003* (Queensland), where:

(a) the health care caused or contributed to the death, or a failure to provide health care caused or contributed to the death

(b) death was an unexpected outcome of the health care being provided.

For the purposes of the *Coroners Act 2003* (Queensland):

- ‘Health care’ means a health procedure or any care, treatment, advice, service or goods provided for the benefit of human health.
- ‘Health procedure’ includes any dental, medical, surgical, diagnostic or other health-related procedure, including a consultation or giving an anaesthetic or other drug.